

Crestor (rosuvastatin)
Antilipidemic Drugs I - Prior Authorization Request Form



5625

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) TRICARE Mail Order Pharmacy (TMOP) OR the TRICARE Retail Pharmacy Program (TRRx). Express Scripts is the TMOP and TRRx contractor for DoD.

**MAIL ORDER
and
RETAIL**

- The provider may **call: 1-866-684-4488**
or the completed form may be **faxed to:**
1-866-684-4477

- The patient may attach the completed form
to the prescription and **mail** it to: **Express Scripts, P.O. Box 52150, Phoenix, AZ 85072-9954**
or **email** the form only to:
TpharmPA@express-scripts.com

Prior authorization criteria and a copy of this form are available at: http://pec.ha.osd.mil/forms_criteria.php. This prior authorization has no expiration date.

Step 1 Please complete patient and physician information (please print):

Patient Name: _____	Physician Name: _____
Address: _____	Address: _____
_____	_____
Sponsor ID #: _____	Phone #: _____
Date of Birth: _____	Secure Fax #: _____

Step 2 Please complete the clinical assessment:

1. Is the request for Crestor 5 mg?	<input type="checkbox"/> Yes Proceed to Question 2	<input type="checkbox"/> No Proceed to Question 3
2. Has the patient had a trial of lovastatin (Mevacor), pravastatin (Pravachol), simvastatin (Zocor), or Lipitor (atorvastatin)?	<input type="checkbox"/> Yes Please sign and date below	<input type="checkbox"/> No Proceed to Question 4
3. Has the patient had a trial of Lipitor (atorvastatin) at a dose greater than or equal to 40 mg OR simvastatin (Zocor) 80 mg¹?	<input type="checkbox"/> Yes Please sign and date below	<input type="checkbox"/> No Proceed to Question 4
4. Is the patient taking a concurrent drug that is metabolized by the CYP3A4 system?	<input type="checkbox"/> Yes Please sign and date below	<input type="checkbox"/> No Proceed to Question 5
5. Does the patient require an LDL lowering greater than 55%?	<input type="checkbox"/> Yes Please sign and date below	<input type="checkbox"/> No Proceed to Question 6
6. Does the patient require primary prevention with Crestor (rosuvastatin) and is not able to take Lipitor (atorvastatin)?	<input type="checkbox"/> Yes Please sign and date below	<input type="checkbox"/> No Coverage not approved

¹ The FDA has updated the labeling for simvastatin 80 mg warning of the potential increased risk of muscle injury with the 80 mg dose of simvastatin compared to lower doses of simvastatin and possibly other statin drugs. Patients are not required to try simvastatin 80 mg; the criteria notes this dose for those patients who may have already tried simvastatin 80 mg.

Step 3 I certify the above is true to the best of my knowledge. Please sign and date:

_____ Prescriber Signature	_____ Date
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Implementation: 6 October 2010